

Demographic Crises and Ageing policy ideas in the fields of health and long-term care. Comparing the EU the WHO and the OECD

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Introduction

During the last decades several international organizations have been concerned with ageing policies, focusing on different kinds of political areas such as work, poverty, pensions, health and long-term care. Demographic changes transform societies and challenge existing institutional solutions and policies across the world. Concerns are made about the future finance of pensions and health systems, scarcity of labour especially within the care sector, worries over ageism, exclusion and marginalisation of older people, and fears of undermining the generational contract, i.e. the ways goods and burdens ought to be shared in society between working age cohorts and older generations. Against this background, the need for policies addressing these challenges has increasingly been put on the agenda at different governance levels.

The conceptions of ‘productive ageing’ and ‘the burden of ageing’ (Walker 2009:79) dominated the global discourse during the 1980s and 90s. . Productive ageing appeared in the US in the 1980s and originated from a previous paradigm of ‘successful ageing’, which was again a response towards the then (1960s) dominating disengagement theory. The latter emphasised increasing withdrawal, as people aged, from key spheres of life and its adherent roles and relationship (Walker 2002). Over the last decade a new paradigm of ageing policy has been flagged under the heading of *Active Ageing*. Generally, ‘active ageing’ could be seen as a reaction to the concept of ‘productive ageing’, emphasising a broader perspective on activities than economically productive ones or the two discourses may be seen as an internal tension between different versions within the active ageing paradigm. Recently discourses on ageing policy have to a large extent been attached to the more general discourse on ‘the sustainability of the welfare state’ which have gained prominence in the western world not least due to interpretations of the demographic development (crisis) in these countries (cf Kildal 2009; Nilssen 2009).

This paper elaborates on the basic ideas regarding ageing policies in the fields of health and work as they are expressed in three international organizations; the EU, the OECD and the WHO. Ideas are powerful rulers of the world – more powerful than is commonly understood (Keynes [1936]2007: 383). Thus, one of the most important task of the social sciences is therefore to arrive at a rational understanding of the ‘ideas’ for which men struggle, and to judge them critically (Weber [1904]1969:53f.). This paper constitutes a first step towards such analyses, concentrating on a comparison of basic

ideas and policy discourses on aging policy between the three chosen international organizations.

Conceptual framework

Ideas are means to understand a multifaceted social world by applying certain concepts that help to reduce complexity. Ideas may also provide a normative function by diagnosing the social world. Policy ideas, as understood here, contain both normative and cognitive functions, as well as prescriptions for actions. What kind of policy ideas different actors proliferate influence political solutions, as they tell us some policy stories about how the social world is constructed, what norms that are important to protect or reject, and why things go wrong. This ideational perspective stresses the non-reducible role of ideas and their relative independence from material self-interests and power (Ervik, Kildal and Nilssen 2009:6).

There is a need to differentiate between various aspects of ideas and to distinguish between levels of ideas (Ervik, Kildal and Nilssen 2008). In this paper we differentiate between cognitive and normative framing ideas and programmatic ideas (Campbell 2002). Framing ideas are, in our case, oriented towards how policy makers such as the OECD, the EU and the WHO present policies in order to make them political acceptable. i.e. how they are justified (cognitively and normatively) in the most important policy documents. Programmatic ideas are instrumental (cognitive) ideas that facilitate policy making by specifying how to solve particular problems; they are oriented towards the instrumental relationships between means and ends.

The main research question in this paper concerns how such ideas are expressed in the policy discourse on ageing policies in the field of health/long-term care in the EU, WHO and the OECD. 'Policy discourse' is perceived as:

“..coherent systems of ideas that link normative judgements about policy goals to practical accounts of the policies likely to reach them. Such discourses may legitimate particular policy direction to the extent that they reflect widely held values” (Taylor-Gooby and Daguerre 2002:6)

A policy discourse both contains a set of policy ideas and values and a process of interaction focused on policy formulation and communication (Schmidt and Radaelli 2004:184). The communicative dimension turns the spotlight on how different policies are framed by

providing a common language in order to persuade the public and other relevant actors that the recommended policies are necessary and appropriate (cf Schmidt 2001:249-50). We will, however, add that (cognitive or normative) framing ideas also may influence policy actors' interpretations of the world (e.g. the way social problems are constructed) and thus affect the formulation of programmatic ideas.

Focusing on policy discourses help to link together different kinds of ideas, such as frames and programmatic ideas, in the preparation of different approaches to ageing policy made by the three international organizations (Nilssen 2009). For instance, policy actors may use both cognitive and normative arguments in the justification of specific programmatic ideas and the same kinds of framing ideas may be linked both to similar and different kinds of programmatic ideas.

Comparing ideas and policy discourses between three international organizations implies an 'idea-centred' perspective (Beckman 2005) directed towards the arguments presented in relevant policy documents on the field of aging policy and health/long-term care. The focus of attention is the content of, and relationship between, programmatic and framing ideas as they are expressed by the organizations. What are the differences and similarities of the policy discourses between the EU, the OECD and the WHO?

Ideas and policy discourses do not take place in an institutional lacuna. International organizations have different traditions, goals, functions and stakeholders; they are compounded by different kinds of expertise, belong to different kinds of network (e.g. epistemic communities or political movements) and may communicate more or less systematically between each other. In order to understand and explain differences and similarities on the ideational level between the three organizations, we have to bring in such contextual and institutional elements into the analyses. This paper, however, is principally confined to the first 'idea-centred' stage of analysis.

The EU

The EU's approach to ageing is expressed in the Commission, *Towards a Europe for all Ages* (COM (1999) 221 final), and in the following up conference the same year, *New paradigm in Ageing Policy*. This conference aimed at "rounding off the UN Year of Older People and

drawing up the agenda on how to take the momentum into the next century.”¹ Both in the Communication as well as in the following up conference, the concepts of active and healthy ageing are essential and closely connected, and also closely associated with the employability of ageing workers:

“Active ageing is about adjusting our life practices to the fact that we live longer and are more resourceful and in better health than ever before, and about seizing the opportunities offered by these improvements.”²

Four challenges are sketched: decline of the population in working age, pressure on pensions systems and public finances, growing need for care, and growing diversity among older people in terms of resources and risks. These challenges led the Commission to the following four policy conclusions (COM (1999) 221 final:5):

1. to combat unemployment in order to increase the employment rate in Europe, by promoting lifelong learning and flexible working arrangements, as well as reviewing tax and benefit schemes to improve work incentives.
2. to further modernize and improve social protection policies, especially to reverse the trend towards early retirement.
3. to support research relating to health policies and old age care.
4. to develop policies against workplace-based discrimination and social exclusion.

In April 2004 The Commission proposed to extend the OMC on social inclusion to the areas of health and long-term care in order to establish a common framework to support member states in the modernization of their systems (COM (2004) 304). It is stated that

“improving access to care is a way of mobilising the potential of the EU’s workforce in the context of shrinking active population.. ()...care policy should be seen as an active employment policy tool, as it increases the social and occupational integration prospects of jobseekers.” (ibid.:5).

Member states were to present preliminary statements regarding the challenges faced by health care and long-term care³ in spring 2005 and submitted national reports on social

¹ http://ec.europa.eu/employment_social/soc-prot/ageing/news/paradigm_en.htm

² Ibid.

³ According to the Joint Report on Social Protection and Social Inclusion (2008:81) long-term care is understood as in the OECD: “The OECD has defined long-term care as “a cross-cutting policy that brings together a range of services for persons who are dependent on help with basic activities of daily living (ADLs) over an extended period of time”. Elements of long-term care include rehabilitation, basic medical services, home nursing, social care, housing and services such as transport, meals, occupational and empowerment activities, thus also including help with Instrumental activities of daily living (AIDLs). (Joint report 2008:81)

inclusion, pensions and, for the first time, health care and long-term care in September 2006 (Joint report 2007). The preliminary reports identified issues for further work and contributed to the Commission's proposal for common objectives (COM (2006) 62). The three main objectives were to improve access to health care and long-term care (to fight inequalities), to improve the quality of such services and to secure financial sustainability.

In a memorandum from November 2005 the Social Protection Committee stated that perhaps the most important challenge concerning health and long-term care was population ageing.

“more people are living longer as a result of rising life expectancy and the share of old and very old people in the population is increasing. Ageing leads to new patterns of morbidity and mortality such as an increase in chronic and degenerative diseases (e.g. neuro-degenerative and musculoskeletal disease). Consequently, ageing will increase the pressure on the services to provide more and better curative medical care but also more rehabilitative, nursing and social care than currently provided.” (Social Protection Committee 2005:3).

All member states were committed to universal coverage of the entire resident population, although universal rights to care did not mean universal access. In and between member states there are large inequalities in access following both social and geographical dividing lines. Staff shortages were also seen as a challenge to the services. They pose a threat to access (as they can lead to a lack of staff in certain geographical areas or specialties) and to the financial sustainability of the system as well (as wage costs tend to increase when resources are scarcer and/or in order to retain sufficient numbers in the sector). Staff shortages were found to be related to ageing.

“Ageing affects not only the demand for care, but also labour forces. Currently, the health and social sector is an important employment creator: the sector employs a significant proportion of the population many of which are highly skilled. As a result of ageing, patient's needs are likely to require increases in staff numbers and efforts to retain existing staff (including high skilled people). Yet, more and more care professionals reach the retirement age and it becomes increasingly difficult to replace them. ... It is also likely that they (these emerging staff shortages) will lead to an increase in costs, threatening the financial sustainability of the services.” (Social Protection Committee 2005:4)

The Lisbon European Council of March 2000 had stressed that social protection systems needed to be reformed in order to be able to continue good quality health services in the face of the demographic challenges and prospective increases in Health and Long-term care expenditure (Joint Report 2008:80). Hence, one significant point of attention in the OMC on social inclusion/social protection has been to secure sustainable health and long-term care

systems within the union, although without undertaking a trade-off between sustainability, access and quality.

“Offering high quality care to all residents is costly, and what is medically and socially desirable may not be within the reach, given the constraints on public budgets and the limited scope of raising additional resources through increased contributions and taxes. A key question which could be addressed through the OMC is, therefore, whether one can, to some extent at least, escape the dilemma of having to trade-off financial sustainability, on the one hand, against access and quality, on the other.”
(Social Protection Committee 2005:32)

One important framing idea in the OMC process is that health policy and efficient health care systems (through promotion, prevention and curative care) can make a major contribution to employment in all sectors, including the care sector, by ensuring that the working age population is and remains healthy and that a healthier population can not only reduce the future cost of care but also contribute to economic growth through higher productivity and longer working lives. Ongoing pension and healthcare reforms is seen to have a positive impact both on the sustainability of public finances and on labour market behavior. Successful action on healthcare improves the quality of the labour force, and in particular the employability of older people (Joint report 2008:111; COM (2006) 62:6) According to the Social Protection Committee (2005:85) rehabilitative services should be provided in order to allow, where possible, the patient’s reintegration within the labour market. Pension policy is also understood to play an important role in tackling health inequalities in old age. Member states are focusing on ensuring higher employment rates among older people and adequate retirement incomes which can be important in reducing social and income inequalities and in ensuring access to services for the elderly (Joint report 2008:79).

Good health and long-term care systems are seen to have a major impact on employment in general. Improving the health status of the population will allow more people to stay on the labour market and will reduce early labour market exits due to invalidity, while access to professional long-term care services allows those who would otherwise have to provide informal care to remain in formal employment. (Social Protection Committee 2005:29)

Health and long-term care thus become a part of a more general discourse on the sustainability of the welfare state that permeates the EU social inclusion strategy, i.e. the modernization of social protection systems, implying a close link between social policy and labour market policy (Nilssen 2009). The majority of European countries are concerned with

the future financial sustainability of their long-term care systems and their ability to cope with demographic developments (Joint report 2008:88).

There are, however, some more challenges to the attainment of this goal. The sustainability of informal provision of long-term care provided by family members and friends, poses a serious challenge by the fact that women are increasingly participating in the formal labour market (Joint report 2008:90). The challenge of human resources development to sustain health and long-term care services in the face both of increased demand and scarce labour resources is also widely flagged by the member states. One common response is the emphasis on promoting prevention, healthy lifestyles and healthy ageing (COM (2006) 62:9). The Social Protection Committee (2005:32) emphasized that it will be important to explore through the OMC how member states can promote healthy and active life styles (notably 'healthy ageing', but also throughout the life cycle to prevent obesity, smoking, alcohol and drug abuse), health and safety at work and more preventive care (e.g. screening) and to what extent this can contribute to an improved health status and to lower expenditure on health and long-term care.

The purpose of the report was to make it clear that the challenge of ageing populations will require comprehensive reforms addressing the fiscal, financial and labour market implications of ageing, as well as the implications for pensions, social benefits and long-term care. The report's messages were rather strong, emphasizing the negative impacts on dominant social and economic institutions and structures.

In 2009 *Ageing Report* (COM (2009) 180 final), ten years after the Commission's first Communication on Active Ageing, the opportunities created by ageing societies are called into attention, although the budgetary impact of ageing is an essential issue as well. It is maintained, that a rising of the retirement age, restricting access to early retirement schemes, and stronger link between pension benefits and pension contributions may create a better incentive to remain in the labour market. Furthermore, ageing societies bring new opportunities to innovative firms through the demand for new goods and services (ibid.:2, 4-5):

“Europe's changing demographic composition can also present an opportunity for the development of products and services geared to the needs of older people. New technologies can be developed and allow older people to stay autonomous and live longer in their own homes, to transform the delivery of care (ibid.: 9).

Long-term care will also require increased public spending. Not only demographic factors, but also factors like changes in family structures, higher labour force participation of women and increased geographical mobility, could reduce the availability of informal care, especially for countries whose formal care systems are less developed.

Recently the EU seems to have incorporated the WHO concept of ‘autonomous ageing’ (see below) in its ageing policy. In COM (2007) 332 final, *Action Plan on Information and Communication Technologies and Ageing*, the Commission propose to support an “action plan on ageing well in the information society” where three areas are addressed: Ageing well at work, in the community, and at home. In the last area the importance of maintaining a high degree of independence, autonomy and dignity is underlined (ibid.:4). This applies also to the Ageing Report from 2009, which calls attention to the opportunity that the changed demographic composition represents for the development of new technologies that “allow older people to stay autonomous and live longer in their own home” (COM (2009): 9). Nevertheless, it is the economic and budgetary impact of ageing that still is in the centre of consideration.

The OECD

In the report *Maintaining Prosperity in an Ageing Society* from 1998, the OECD describes the demographic challenge, their principles for reform and the kind of practical action that will be needed to address them. The purpose of the report was to make it clear that the challenge of ageing populations will require comprehensive reforms addressing the fiscal, financial and labour market implications of ageing, as well as the implications for pensions, social benefits and long-term care. The reports messages were rather strong, emphasizing the negative impacts on dominant social and economic institutions and structures. Of the seven principles for reform that the OECD are proposing, two of them concerns work and health while the others mainly deal with public pension systems, taxation, social transfer programs and fiscal consolidation (ibid.:18-26). They are emphasizing the importance of ‘active ageing’, which is

“ - the capacity of people, as they grow older, to lead productive lives in the society and economy. Active ageing implies a high degree of flexibility in how individuals and families choose to spend their time over life – in work, in learning, in leisure and in care-giving” (ibid.:14)

Public policy can foster 'active ageing' i.a. by providing support that widens the range of options available to individuals by medical interventions. As work and health are closely related, and the OECD recommends that

“there should be greater focus on cost effectiveness, on medical expenditure and research that are focused on reducing dependence, and on explicit policies for providing care to frail elderly people” (ibid.:23)

The increasing social spending obligations on public pensions, health and long-term care cannot be financed by raising payroll taxes, as these would be so high as to discourage work effort. The OECD therefore proposes that in the future, spending in these areas must be contained. A central challenge is also to ensure that the future expenditures on long-term care are cost-effective and meet the most pressing requirements, which is reducing time spent in dependence, and time in chronic care (ibid.:13-14).

In recent years, the organization writes less about 'active ageing', although activation, ageing and employment policies are as important as before. In an influential report from 2006, with the same title as the WB report two years later, *Live Longer, Work longer*, the OECD presents a new agenda of reform which does not focus exclusively on the negative effects of population ageing, but also give attention to the opportunities and choices related to the population and workforce ageing. The key message is now

“..that population ageing is both a challenge and an opportunity. If nothing is done, population ageing poses serious economic and social challenges. But it is also a tremendous opportunity if longer and healthier lives are matched by longer working lives.” (OECD 2006:3).

That the ageing population no longer is simply portrayed as a burden parallels the EUs policy ideas. The report also parallels the EUs approach by emphasising the importance of a lifecycle perspective, as

“Clearly the experience of workers at younger ages will have an impact on their labour market decisions and outcomes when older” (ibid.:135).

However, this broadening of approaches to population ageing does not seem to concern elderly people's quality of life in general, but is restricted to their employment opportunities. One of the main arguments in the report is that much of the reform effort to date has concentrated on pension systems and the pressure on economic growth, while it seems just as important to increase employment opportunities for older workers. Thus a broader strategy to tackle population ageing would be a useful approach

“..since it may help to ensure that policies to cope with population ageing are more coherent and better co-ordinated. It can also serve to raise awareness more generally about the challenges and opportunities arising from population ageing and broaden the public debate about the appropriate public policy response beyond just the implications for pension reform” (ibid.:138).

Thus the challenges related to population ageing may be more easily met by utilizing better the potential labour resources of older people. There are several factors that may increase job opportunities for older people, among which health is an important one. And ‘healthy ageing’ seems to have become a more important issue in later years, cfr. an OECD health working paper from 2009 that reviews policies in this area. In the concluding assessment the OECD states that maintaining health in old age will

- increase the probability that individuals can and will work longer and retire later;
- Once in retirement, more healthy individuals can help care for their partners or elderly relatives, for younger generations and act as a labour reserve for community support activities. Thus, they can become an important resource for the economy and for society more broadly;
- As lifetimes lengthen, the need to care for individuals in costly institutional environments will be delayed, thereby slowing the continuing growth in health and long-term care spending (OECD 2009:25).

For the OECD, ‘Healthy Ageing’ policies primarily seem to be justified by financial concerns – the independently welfare of the elderly is hardly mentioned. This is in contrast to the WHO, which pays great attention to improving the well-being of the elderly. However, despite the various definitions of ‘active’ or ‘healthy’ ageing, the concrete programmes and policies that they recommend are much the same, according to the OECD (2009:8).

The WHO

As suggested, this organization takes a far broader view on ‘active ageing’ than the EU and OECD, and promotes a holistic, more comprehensive public policy.⁴ In the policy document from 2002, *Active Ageing: A Policy Framework*, they declare that “Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age.” The Policy Framework opens by declaring that it intends to

⁴ Ideas of active ageing emerged already in the 1960s. The concept itself, however, was formulated by the WHO (Kasneji 2007).

inform discussion and the formulation of action plans that promote healthy and active ageing (WHO 2002:12). The framework was developed by WHO's Ageing and Life Course Programme as a contribution to the Second United Nations World Assembly on Ageing in 2002. The WHO explicitly states that 'active' refers to

“continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. Older people who retire from work, ill or live with disabilities can remain active contributors to their families, peers, communities and nations. Active ageing aims to extend healthy life expectancy and quality of life for all people as they age.” (Ibid.).

The WHO argues that countries can afford to get old if governments, international organizations and civil society enact 'active ageing' policies and programmes that enhance the health, participation and security of older citizens.

“In all countries (...) measures to help people remain healthy and active are a necessity, not a luxury” (ibid:6)

WHO stated that policies and programmes should be based on the rights, needs, preferences and capacities of older people and a life course perspective that recognizes the important influence of earlier life experiences on the way individuals age. In general, maintaining autonomy and independence as one grows older was defined as a key goal for both individuals and policy makers.

Autonomy was seen as the perceived ability to control, cope with and make personal decisions about how one lives on a day-to-day basis, according to one's own rules and preferences. Independence was understood as the ability to perform functions related to daily living – i.e. the capacity of living independently in the community with no and/or little help from others. This approach was based on the recognition of the human rights of older people and the United Nations Principles of independence, participation, dignity, care and self-fulfilment- which implied a 'right-based' approach that recognized the rights of people to equality of opportunity and treatment in all aspects of life as they grow older.

Concentrating on autonomy and independence, functional health in everyday life became a crucial quality of 'healthy ageing'. This approach was founded on the development of a scientific base for measuring functional status, emphasising a person's ability to perform the activities necessary to ensure well-being, embracing the integration of biological, psychological (cognitive and affective) and social domains of function (Heikkinen 1998:2).

Firstly, healthy ageing involves individual behaviour and lifestyles. For instance physical activity in daily life is considered important in the prevention of both physical and mental illnesses (cf Heikkinen 1998; WHO 1998) and one important question discussed by the WHO is how to encourage such activities. For instance WHO stresses the importance that health care personnel explain why it is necessary, useful or beneficiary to engage in physical exercise (WHO 1998:13). The WHO also signifies the importance of lifestyle changes:

“Stopping smoking, drinking less, getting to the right weight, eating better food and exercising more will make people feel better at almost any point in their lives. These lifestyle changes are frequently recommended for people who have already developed diseases, and they can slow or stop the progress of a disease, or at least make it easier to cope with health problems” (WHO 2005:9)

Healthy ageing is supposed to increase the autonomy, independence and hence the quality of life of older people. “As people age, their quality of life is largely determined by their ability to maintain autonomy and independence” (WHO 2002:13). Secondly, healthy ageing implies actions from governments, communities and health workers. For instance, governments must secure safe food, clean air, good working conditions, safe neighbourhoods etc. Communities and local governments have a responsibility “to help people help themselves” (WHO 2005:10). Hospitals and medication, access to housing, healthy food and opportunities to mix with other people are examples of local responsibilities considered important for healthy ageing. Old people also often need to receive help from health professionals and these professionals “can provide valuable health advice on how to prevent illness, diagnose disease in its early stages and provide support for treatment to either cure or control the progress of disease.” (ibid:10).

Healthy ageing becomes a precondition for active ageing. According to the framework, the term ‘active ageing’ was adopted by the WHO in the late 1990s in order to express a more inclusive message than ‘healthy ageing’ and to recognize factors in addition to health care that affect how individuals and populations age (WHO 2002:13). According to Walker, by emphasizing the health and well-being aspects of active ageing, the WHO documents represented a paradigm shift away from concept of ‘productive ageing’ that had been significant in the transnational debates on ageing (Walker 2009:86). However, also the WHO declares that there are good economic reasons for enacting “policies that promote active ageing in terms of increased participation and reduced costs in care” (WHO 2002:17). By

participation, though, they do not restrict this to work in the formal labour market. The WHO will not “ignore the valuable contribution that people make in work in the informal sector...()...and unpaid work in the home” (ibid.:32).

The WHO vision of healthy and active aging in the 21st century requires a wide-ranging and multisectoral approach, which implies the simultaneous involvement and engagement of many sectors of society including health and social services, education, employment, finance, social security, housing, transportation, and both rural and urban development (Ibid.:46). The definition of Active ageing also implies a life course perspective, which recognizes that older people are not one homogeneous group and that individual diversity tends to increase with age and diversify the needs. Interventions that create supportive environments and foster healthy choices are important at all stages of life (Ibid.:14). Health, participation and security are leading ideas. The rights of people to equal opportunity and treatment in all aspects of life as they get older, is emphasized all through the policy framework.

Comparing policy discourses

The concept of ‘active ageing’, coined by the WHO, was later adopted by the EU as common concept for the policy response to population ageing (Kasneci 2007). Since the early 1990s interpretations of the demographic development in Europe have brought ageing policy on the EU political agenda, and in 1999 ‘active ageing’ policies became a major concern at the EU level and in its member states. In *Towards a Europe for all Ages* (Com (1999) 221 final), the Commission put a strong focus on increasing the employment rate among older workers, on modernizing the social security policies, and on developing adequate responses to ageing in health and care (ibid.:5). In 2004 the area of health and long-term care was incorporated to the OMC on social inclusion and social protection and the EU Social Inclusion Strategy. This strategy has been dominated by programmatic ideas founded in a discourse on ‘Active Social Inclusion by Work’, implying that social inclusion primarily is a question of labour market participation (Nilssen 2009). Based on the background of the demographic development of the EU countries, the dominating framing discourse is what we have termed ‘the Discourse on the Sustainability of the Welfare State’ (Kildal 2009; Nilssen 2009) arguing that the economic sustainability of the welfare state is dependent on institutional change; i.e. to “modernize” the welfare state in order to meet the economic challenge of the aging society.

The inclusion of health and long-term care in the OMC on social inclusion also entailed that institutional modernization became an important focus point in these policy areas; i.e. to secure sustainable health and long-term care systems within the union without having to make a trade-off between quality and access on the one hand and financial sustainability on the other. One important aspect of the OMC/social inclusion has been to make a closer relationship between social policy and labour market policy (Nilssen 2009). This is also reflected on the field of health policy. The EU is stressing that efficient health care can make a major contribution to employment in all sectors by providing a healthy population. Health is closely related to the idea of ‘productive aging’ by stating that healthcare may improve the quality of the labour force and thus contribute to economic growth, the employability of older people and longer working lives. One important programmatic idea is to strengthen rehabilitative services in order to reinforce patient’s reintegration within the labour force. Access to professional long-term care is also considered important because it render possible that informal care providers remain in formal employment. On the other hand do women’s participation in the labour market increase the pressure on the health and long-term care systems and enhance possible recruitment problems within these policy areas.

Another common programmatic response to the possible pressure on health and long-term care systems due to population ageing has been a general focus on promoting prevention, healthy live-styles and healthy ageing. In opposition to the ideas of ‘healthy ageing’ promoted by the WHO, the EU do not primarily frame such ideas by focusing on individuals quality of life, autonomy and independence, but by economic arguments based in a general economic discourse on ‘the Sustainability of the Welfare State’.

Regarding the OECD, the early signs of what would become the common ground among international governmental organizations (IGO) was presented in two OECD reports from 1988 (a, b) (Walker 2009). These reports, followed by others as well, initiated a ‘burden of ageing’ discourse that prescribed reductions in public and occupational benefit pension schemes and increase in private contributive ones (ibid.:79). This idea of a ‘public burden of ageing’ is expressed in the 1998 Report as well, although some new ideas of active, healthy and productive ageing populations were presented, ideas that also turned out to become rather influential. It settled the framework for policy recommendations in years to come by stressing the ageing society’s challenge to the financial foundation of prosperity. However, in this report “a limited window of opportunity” to put reforms in place was introduced as well, as

the main demographic changes will start in about 10-15 years (OECD 1998:18). The main message was nevertheless rather tough and the policy prescriptions were likewise. The need for comprehensive economic and social reforms should be met; first and foremost a restructuration of the allocation of work and leisure. The strong disincentives to work provided by the interaction between current pensions systems, tax systems and social programs should be removed in order to make the workers remain in the workforce. Coupled with effective steps to improve the employability among older workers, this could be an important contribution to sustaining the growth of living standards (OECD 1998:14).

The OECD is particularly worried about how the demographic development will affect the public spending on policy areas such as public pensions, health and long-term care and indirectly how such expenditures will influence labour market participation. The organization is stressing the necessity of cost-effectiveness in the distribution of such services and the need of research that are focused on reducing people's dependence on public services.

The programmatic ideas presented in the OECD Report from 1998, obviously are closely related to dominant institutions and structures which main concern is the economy, and the ideas are thus clearly rooted in an overarching justifying *discourse on economic sustainability* concerning the financial foundation of the welfare state. The ideas are addressing the financial structures and the labour market and are evidently justified by economic arguments.

This also regards the ideas expressed in the more recent policy documents from the OECD. Even if the main discourse on ageing has changed from a 'burden of ageing' to one on 'positive' or 'successful ageing' which challenges the negative notions of ageing, the discourse is expressing the same programmatic ideas. The lifecycle perspective that was presented in the mid 2000 is neither bringing new ideas into the scene. That the programmatic ideas are valid for the whole population does obviously not require new justifying arguments. Economic sustainability is an argument that might justify most policy ideas.

Issues concerning ageing have also constituted an important policy area for WHO the last decades. The organization has played an important role in the changing discourse on aging from a narrow perspective of 'productive ageing' towards a wider and more inclusive approach on active ageing (Walker 2009). The WHO has described the demographic "revolution" (global ageing) as both a triumph for public health policies and social and

economic development, and as a challenge for many countries in the world. The WHO's definition of active ageing as "the process optimizing opportunities for health, participation and security in order to enhance the quality of life as people age" (WHO 2002:6, 12) has been important in the changing view of old age as hallmarked by passivity and dependency towards emphasizing autonomy and participation.

On the programmatic side the idea of 'healthy ageing' has played a crucial role in the WHO discourse on ageing. The relationship between health and activity is captured by the concept of 'functional health'. Several indicators of 'functional health' are worked out on the basis of ongoing research⁵. Maintaining functional ability is one important aspect of healthy ageing. The programmatic ideas of the WHO discourse on 'active ageing' are to a large extent oriented towards 'healthy ageing'. For instance one important task for health professionals is to encourage old people to be physical active. However, 'healthy ageing' consists of a broader perspective than individual activities, embracing public policy areas such as food, air, working conditions, housing and opportunities for social participation. The Life Course Approach implies that 'healthy aging' does not only concern old people but people of any ages and is among other things affected by personal life styles.

As distinct from the EU and the OECD, the WHO discourse on 'active ageing' is not primarily framed by cognitive and economic arguments. Stressing concepts like 'quality of life', 'independence' and 'autonomy' entails more normatively oriented framing ideas. Quality of life is understood as an individual's perception of his or her position in life in relation to their goals, expectations, standards and concerns (WHO 2002:13) and is closely related to individual autonomy and independence. This is also considered important in the field of long-term care. Long-term care is defined as "the system of activities undertaken by informal caregivers (...) and/or professionals (...) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfillment and human dignity" (WHO 2002:22).

⁵ These indicators are normally distinguished between Physical activities of Daily Living (ADL) concerning various self-care activities (eating, dressing, personal hygiene etc) and Instrumental Activities of Daily Living (IADL) embracing functions related to household management, use of public transport, running errands outside the house etc.

Focusing on quality of life, autonomy and independence implicates that ‘active ageing’ cannot be restricted to certain kinds of activities such as participation in the labour market. The possibility to work will of course be a crucial part of the quality of life of many people and thus an important aspect of ‘active ageing’ policies, but the WHO discourse on active aging covers a much wider range of activities than does the more economical oriented idea of ‘productive ageing’.

Conclusion

The demographic development of the populations particularly in the western world (ageing societies) is an essential point of departure for the discourses on ageing policies in the EU, the OECD and the WHO. Although the concept of ‘crisis’ is not appropriate to use in order to describe any of these organizations interpretation of this development, they certainly accentuate various, and similar, kinds of challenges. The policy solutions are yet not quite the same among the three organizations, although the EU and the OECD present quite comparable ones. Both organizations are portraying rather similar and pessimistic pictures of how the ageing population threatens to destroy the basis for our economy, welfare and prosperity. Even if the ageing discourses changed during the 1990’s, from constructing elderly people as dependent, passive recipients of public pensions and social assistance, to a positive social construction of them as potentially healthy, active participators, the overall challenge and policy problem is still the pressure that an ageing population put on existing social and economic institutions. Certainly the programmatic ideas articulated by the EU and the OECD are emphasizing different societal institutions. The ideas of the OECD may be described as more general than the EU, representing certain macro-economical ideas for institutional and structural change, while the EU promotes more specific (although quite general) ideas of “modernizing” different kind of welfare state institutions such as health and long-term care. Yet their policy solutions have a striking resemblance in recommending policies that ultimately will contribute to the financial sustainability of the welfare state. In both organizations the main challenges are primarily interpreted within a economic discourse.

The WHO also acknowledges the challenges but adopts a normative, more holistic and comprehensive, and more strongly health-oriented approach to ageing policies. The ‘health’ concept is broad, and so is the concept of an active ageing policy which is viewed far broader than employment. The programmatic ideas, focusing on ‘functional health’, are oriented towards securing the quality of life through age by emphasizing the possibility of autonomy

and independence. Such ideas seem to have achieved some attention in the EU recently, but it remains to see which impact they will have in the encounter with the traditional economic discourse on ageing policy.

Nevertheless, our analyses show that in order to understand similarities and dissimilarities between the organizations, framing ideas are crucial. These ideas tell us how certain problems, such as an aging society, are constructed. Interpreting challenges of the demographic development on the basis of an economic oriented sustainability discourse (EU, OECD) highlights programmatic ideas such as ‘social inclusions through work’ ‘make work pay’, ‘economical incentives’ and in the field of ageing policy, ‘productive ageing’. Interpreting this development on the basis of a normative discourse on quality of life, autonomy and independence (WHO) highlights programmatic ideas such as functional health and ‘healthy ageing’. Framing ideas can thus not only be understood as justifications of programmatic ideas, but must also be perceived as a cognitive or normative interpretive foundation affecting which programmatic ideas that are considered appropriate or necessary in order to solve certain policy problems.

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